Katie A. Semi-Annual Progress Report
Cover Page

Reports are due April 1st and October 1st of each year. Please check the reporting period:

X May 15, 2013 – August 31, 2013 (Initial reporting period) October 18th

☐ April 1st

☐ October 1st

Katie A. Semi-Annual Progress Report Instructions

The Katie A. semi-annual progress reports are required by the Implementation Plan and should include information on the delivery of services occurring during the six months immediately preceding the report. The first of these reports is due on October 18, 2013, and includes information about services delivered May 15, 2013 through August 31, 2013. Enclosures 1 and 2 provide templates for the semi-annual report to be jointly prepared by Mental Health and Child Welfare Departments and submitted electronically.

Enclosure 1, Part A

MHPs and CWDs are to provide the total unduplicated numbers of subclass members, along with a breakdown of those subclass members grouped by the services being provided during the reporting period using the attached template. If the above numbers are not available, MHPs and CWDs are to provide an explanation of why they are not available and an estimated date of when the numbers will be available for each template item in Column 2 of Enclosure 1. This section (see Enclosure 1, Part A) of the progress report should build on the information counties provided in Section I of their Service Delivery Plans regarding identification of subclass members and the process used to determine their needs.

Enclosure 1, Part B

MHPs and CWDs are to provide an estimated projection of the number of subclass members that will be provided with ICC and IHBS by April 1, 2014, along with strategies and timelines to ensure access to ICC and IHBS, when medically necessary, , and consistent with the Core Practice Model.In the column on Enclosure 1, Part B that reads "Strategy/Timeline Description", MHPs and CWDs should describe their plans for the identification of subclass children and youth who are identified in Enclosure 1, Part A, 4, 5, 6, 7 and 8 using the identifier and claiming codes for ICC and IHBS services.

Enclosure 2

CWDs and MHPs should provide an update to the Readiness Assessment Tool counties completed in May 2013. Describe activities related to each section during the reporting period, including actual or anticipated results. Include activities that support family-centered principles, and promote implementation of the ICC and IHBS using the Core Practice Model. Identify activities that occur jointly and those that occur separately by child welfare and mental health agencies. Include information about barriers, as appropriate, and strategies to address them. For each section, MHPs and CWDs should specify technical assistance or state support needed regarding implementation of CPM, ICC, and IHBS.

Submittal Instructions: Please submit electronically to the Department of Health Care Services at KatieA@dhcs.ca.gov and the California Department of Social Services at KatieA@dss.ca.gov. Reports are due on April 1st and October 1st of each year.

County: _____Shasta County_____ Date: __October 18, 2013_____

Name and Contact Information County Child Welfare Department Representative					
Name:	Maxine Wayda				
Title:	Director				
County:	Shasta County				
Agency Name:	Health and Human Services, Children's Services				
Address:	1313 Yuba Street				
City:	Redding	State:	CA	Zip Code:	96001
Phone:	530-225-5965	E-mail:	mwayda@co.shasta.ca.us		

Name and Contact Information County Mental Health Department Representative					
Name:	Lori Steele				
Title:	Clinical Division Chief				
County:	Shasta County				
Agency Name:	Health and Human Services, Children's Services				
Address:	1313 Yuba Street				
City:	Redding	State:	CA	Zip Code:	96001
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Name and Contact Information (other stakeholders)					
Name:	Amber Condrey				
Title:	Staff Services Analyst				
County:	Shasta County				
Agency Name:	Health and Human Services, Children's Services				
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Phone:	530-225-5853	E-mail:	acondrey@co.shasta.ca.us		

Name and Contact Information (Other stakeholder)					
Name:					
Title:					
County:					
Agency Name:					
Address:					
City:		State:		Zip Code:	
Phone:		E-mail:			

County: _____Shasta County_____ Date: __October 18, 2013_____

PART A: Services Provided at Any Point Within the Reporting Period			
Item #	**Information Requested**	**Column 1 10/18/13**	**Column 2 Timelines**
	For subclass members, provide the numerical count for the following:	Provide the number of children/youth per category	If Column 1 is blank, provide an explanation why the number is unavailable and an estimated date the number will be available
1	In Subclass (unduplicated).	63	This number is lower than our original Readiness Assessment number submitted back in May 2013. Based upon improved Katie A. Evaluation tools we have gone through our previous list and found we had children in the subclass originally who did not meet medical necessity.
2	Receiving Intensive Care Coordination (ICC).	22	13/22 are Wraparound children/youth
3	Receiving Intensive Home Based Services (IHBS).	0	In September, Shasta County began billing for IHBS. In October we began the process of training Organizational Providers who will be assisting in billing for IHBS services. For September 2013 billing 6 clients received IHBS.
4	Receiving intensive Specialty Mental Health Services (SMHS) through a Wraparound Program or Full Service Partnership consistent with the Core Practice Model (CPM), but not claimed as ICC and IHBS. *Do not include youth already counted in2 or 3 above.*	0	All children/youth in Wraparound are receiving ICC – 13 Wraparound kids
5	Receiving other intensive SMHS, but not receiving ICC or IHBS. Examples of intensive SMHS may include: Therapeutic Behavioral Services (TBS), Intensive Treatment Foster Care (ITFC),or Multidimensional Treatment Foster Care (MTFC). *Do not include youth already counted in 2, 3, or 4*	41	
6	Receiving services not reporting in 2, 3, 4,& 5 above.	0	n/a
7	Not receiving SMHS.	0	All Subclass children/youth are receiving some form of SMHS
8	Declined ICC or IHBS.	0	No Children/Youth have declined ICC or IHBS

County: _____Shasta County_____ Date: __October 18, 2013_____

PART B: Projected Services			
Item #	**Service**	**Projected number of subclass members to be served by 4/1/14**	**Strategy/Timeline Description** Provide County action steps and timelines to be used to provide (and claim for) ICC and IHBS to: 1.newly identified children/youth and 2.children/youth identified in Part A, Items 4, 5, 6, 7, and 8 as medically necessary
1	ICC	40	Our electronic medical records system is currently able to process claims. We are waiting for our vendor to release an update that will insert the KTA Loop 2300 REF-DPI on the 837. The update is scheduled to be released in October 25, 2013. 1. **Newly Identified Children/Youth:** We have an established process for Mental Health and Children's Services to refer children for evaluation of Katie A. subclass criteria. • All children coming into care are being screened initially for mental health services. • After the first screen, if they are not open to Mental Health a 90 day screening will occur and then an annual screening for mental health services. • An annual MH screening for children/youth that are already in care as a permanent placement will begin if the child/youth is not currently open to MH services. • If the child/youth meets any Katie A. subclass criteria a Katie A. evaluation is completed and documented. Our Electronic Health Records System is alerted and a special Katie A. Qualifier is given to each child who is in the Katie A. subclass. • A Child and Family Team (CFT) meeting is scheduled within 30 days of the Katie A. evaluation. • ICC and IHBS services will begin being provided if needed based on the needs of the child and the voice and choice of the family. 2. **Children/Youth Identified in Part A, Items 4-8:** • We are currently in the process of implementing the CFT meetings and have developed a meeting outline tool that is similar to our High Risk Team (HRT) Meetings and uses Safety Organized Practice in its delivery. • During the CFT Meeting, for children already receiving other Specialty Mental Health Services, the team will be discussing with the family and child the current services received and whether or not they need to be changed. • If current services are working well we will continue with those services, if they are not working ICC and IHBS services will be utilized.
2	IHBS	35	

County: Shasta County **Reporting Period: May 15, 2013-August 31, 2013** **Date Completed: October 18, 2013**

Please provide an update to the Readiness Assessment Tool counties completed in May 2013. Describe activities related to each section during the reporting period, including actual or anticipated results. Include activities that support family-centered principals, and promote implementation of the ICC and IHBS using Core Practice Model. Identify activities that occur jointly and those that occur separately by child welfare and mental health agencies. Include information about barriers, as appropriate, and strategies to address them.

For each section, please indicate if training or technical assistance from the State is needed. When indicated, CDSS and DHCS will contact the county child welfare and mental health departments for further information. Please note that training and technical assistance needs will be addressed in a coordinated manner through each county's child welfare and mental health contacts.

Use additional pages, if necessary.

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
Agency Leadership *Leadership's experience implementing family-centered services in a collaborative setting.*	• HHSA Mental Health (MH) and Child Welfare (CW) staff is a member of the Small Counties Learning Collaborative. • MH and CW staff are developing a Katie A. policy and procedure, completion December 2013. • MH and CW Management support collaboration between units through weekly meetings. • MH and CW Supervisors have standing monthly meetings. • MH and CW staff are both active in internal Implementation Science workgroups for new program implementation. • The internal Implementation Science Core Team is made up of HHSA CW and MH staff with stakeholders from various units and outside partners. • Working collaboratively with our IT, Accounting, and Managed Care Departments to share information, give feedback and oversee changes.	
Systems and Interagency Collaboration *How collaborative approaches are used when serving children and families.*	• MH and CW have experienced difficulties with our different systems having the ability to support sharing of child welfare and mental health data. • MH and CW are working to establish better ways to share pertinent Katie A. information while still maintaining confidentiality. • An analyst works closely with our IT and Billing Departments to audit our Electronic Health Record system that supplies the number children/youth that are part of the subclass. • Repurposed 2 MH Clinicians to serve Katie A. Class children and have added 1 Clinician to serve the Katie A. Subclass. • Trained all foster care mental health clinicians in Safety Organized Practice and facilitation. • MH and CW are working closely with Managed Care to establish capacity to bill for ICC and IHBS	TA Needed

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
	services including updating treatment plans for all Katie A. subclass kids. • All HHSA MH and CW Staff have been offered HIPPA training, (mandatory training for MH and Public Health Staff). • Infrastructure exists and has been established for collaborating trainings for staff in MH and CW. • In August joint trainings began regarding Katie A. implementation for all Children's staff during the semiannual all Children's Branch Meeting. • Individual MH and CW units were trained collaboratively by MH and CW regarding their specific role in Katie A. as well as an overview of the Core Practice Model.	
Systems Capacity *The collective strength of administrative structures, workforce capacity, staff skills & abilities, and operating resources.*	• Children/youth are screened for possible mental health needs through our MH Screening if over age 5 or the Ages and Stages Questionnaire (ASQ) for those between 0-5. • We have added to our screenings the Katie A. criteria so CW staff can identify criteria related to subclass membership early in the evaluation process. • As part of our ongoing coaching we have trained staff in MH and CW on the MH Screening process and the expectations in terms of timeliness, frequency, and how to refer for services. • Our new MH clinicians have been oriented and trained on Katie A. specifics and their role in the new processes. • All clinicians have attended training on Safety Organized Practice and facilitation of family team meetings. • Developing a written policy for Katie A. process and services, December 2013 expected completion. • MH Manager is working closely with our billing, managed care, and electronic medical record systems to ensure children are given the Katie A. Qualifier and Clinicians are in turn able to bill for ICC and IHBS services.	
Service Array *Available services are culturally responsive and include trauma informed care, evidence based practices, promising practices, innovative practices, and culturally specific healing practices and traditions.*	• The next stage in Katie A. implementation will be to explore non-traditional services and supports that exist in our community. • Evidence Based practices such as Triple P, Safe Care and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) are utilized by staff and community partners to deliver services to families in our system and in our community. • Current practice for High Risk Team (HRT) and Family Team Meeting (FTM) are established to help families meet specific, individual needs and build on strengths while working on needs. • Contracts in place with Organization Providers to supply In Home Based Support Services to any Katie A. subclass members who are assigned to an Organization Provider Clinician.	

Readiness Assessment Section	Description of Activities	Training or TA Needed (Y or N)
Involvement of Children, Youth & Family *How Core Practice Model family-centered principles are reflected in current systems.*	• We are modeling our CFT meeting after our current HRT meeting, which allows us to be consistent in practice and utilize Safety Organized Practice structure. We have developed the structure for the CFT meeting and will be auditing for fidelity. • To help with the involvement of families in defining and selecting services and programs we will partner with the Parent Leadership Advisory Group (PLAG) to provide feedback on our various programs. • MH and CW offered a Katie A. Community Workgroup in August where parents, foster parents, youth, tribal partners, Organizational providers, and community trainers were invited to receive training on Katie A. and provide feedback on our Readiness Assessment and Implementation Science plans – participation was unfortunately less than anticipated • Over the next 6 months MH and CW will be going to community groups to get feedback and educate on Katie A (Parent Leadership Advisory Group (PLAG), California Youth Connection (CYC), Tribal Partners, Foster Parent Association, Alcohol and Drug Provider Group, and Court Officials). • Our Court Orientation process has been very helpful in assimilating families to CW and the process for court involvement. • Supporting Father's group, CYC, PLAG, and Foster Parent Association have been effective resources to support families and children.	
Cultural Responsiveness *Agency ability to work effectively in cross-cultural settings.*	• Staff matches the diversity of Shasta County; we have several multi lingual staff members and access to translator services. • Next step will be to research what other counties are doing in our Learning Collaborative to encourage cultural responsiveness. • A future goal is to explore non-traditional services and supports that exist in our community.	Training
Outcomes and Evaluation *The strength of current data collection practices, and how outcomes data is used to inform programs and practice.*	• Currently developing an Implementation Plan which highlights training and communication plans for Katie A. • 2 Analysts assist in the collection and monitoring of data related to Katie A. to help ensure accuracy and timeliness in services. • We are developing a Logic Model to help look at outcomes (fewer placement changes, permanency sooner, lower levels of care, etc.). • For tracking purposes data on subclass children is currently housed in Excel. • We are exploring creating an Access Database to help track the subclass and class.	TA
Fiscal Resources *How fiscal policies, practices, and expertise support family-centered services.*	• Monthly tracking of budget spend downs helps to ensure appropriate use of resources. • Interagency teams and collaborative projects include fiscal expertise. • Contracts and MOU's in place with providers. • Utilization of multiple funding streams to help support mental health needs. • Staff receives ongoing training on the time study process.	